

The Minimum Standard

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed," nor need it affect the various existing types of staff organizations. The word "staff" is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff," the "visiting staff," and the "associated staff."
2. That membership upon the staff be restricted to physicians and surgeons who are (a) full graduates of medicine in good standing and legally licensed to practice in their respective states or provinces, (b) competent in their respective fields, and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.
3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide:
 - a. That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately).
 - b. That the staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and the other specialties; the clinical records of patients, free and pay, to be the basis for such review and analyses.
4. That accurate and complete records be written for all patients and filed in an accessible manner in the hospital - a complete case record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, X-ray and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up and, in case of death, autopsy findings.
5. That diagnostic and therapeutic facilities under competent supervision be available for the study, diagnosis, and treatment of patients, these to include, at least (a) a clinical laboratory providing chemical, bacteriological, serological, and pathological services; (b) and X-ray department providing radiographic and fluoroscopic services.

A Journey through the history of the Joint Commission.



Joint Commission
on Accreditation of Healthcare Organizations

[Home](#) | [Who Am I](#) | [Search](#) | [Sitemap](#) | [Contact Us](#) | [Care](#)

[>JCAHO](#) > [>Accredited Organizations](#) > [Publicizing Yo](#)

Publicizing Your Accreditation

[Celebrate Your Accreditation](#)

[JCAHO Logo Guidelines](#)

[The Joint Commission:
Assessing the Quality of Care
Brochures](#)

[Facts About Joint Commission
Accreditation](#)

[Guidelines For Publicizing Joint
Commission Accreditation](#)

[Frequently Asked Questions](#)

[Promotional Materials](#)

[Sample News Releases](#)

[Accreditation Decisions](#)

[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospital Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

Facts About Joint Commission Accreditation

The mission of the Joint Commission on Accreditation of Healthcare Organizations is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. Joint Commission standards of quality are developed in collaboration with health professionals and others. The Joint Commission stimulates health care organizations to meet these state-of-the-art standards through accreditation and the teaching of quality improvement concepts.

1. The Joint Commission is an independent, not-for-profit organization.
2. An organization voluntarily undergoes a survey by a full team of Joint Commission experts every three years. After being surveyed, the organization receives one of the following accreditation decisions:
 - Accreditation with Full Standards Compliance
 - Accreditation with Requirements for Improvement
 - Provisional Accreditation (a temporary status for newly established organizations)
 - Conditional Accreditation
 - Preliminary Denial of Accreditation
 - Accreditation Denied
3. The Joint Commission evaluates and accredits almost 11,000 hospitals and home care agencies, and more than 7,000 other health care organizations. Joint Commission accreditation is available for:
 - general, psychiatric, children's and rehabilitation hospitals
 - health plans, integrated delivery networks, and other managed care entities
 - ambulatory care facilities, including office-based surgery practices
 - long term care facilities
 - behavioral health care organizations
 - clinical laboratories
 - home care organizations
 - assisted living facilities
4. The Joint Commission is governed by a 28-member

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- > [Patient Safety](#)
- > [Quality Check](#)
- > [Datamart™](#)
- > [Speak Up](#)
- > [Standards On Submission Form](#)
- > [Publicizing Your Accreditation](#)
- > [Sign Up for Newsletter](#)
- > [Accreditation](#)
- > [Looking for a Codman Award](#)
- > [Eisenberg Award](#)
- > [Infomart](#)
- > [Education](#)
- > [Publications](#)

Board of Commissioners, which includes six public members. Board members have diverse experience in health care, business and public policy, and provide policy leadership and oversight to the Joint Commission.

5. The Joint Commission on Accreditation of Hospitals was founded in 1951. The name was changed to the Joint Commission on Accreditation of Healthcare Organizations in 1987 to reflect the increasing diversity of organizations being accredited.
6. More than 400 physicians, nurses, health care administrators and other experienced professionals are employed by the Joint Commission to perform accreditation surveys. In addition, nearly 400 individuals work in the Central Office scheduling surveys, analyzing survey reports, developing standards and performance measures, producing publications and educational programs, and serving the needs of accredited organizations and the public.

[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospitals](#) | [Laboratory Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

[Home](#) | [Who Are We](#) | [Search](#) | [Sitemap](#) | [Contact Us](#) | [About Us](#) | [Career Opportunities](#) | [Privacy Policy](#)

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Joint Commission
on Accreditation of Healthcare Organizations
[Home](#) | [Who Am I](#) | [Search](#) | [Sitemap](#) | [Contact Us](#) | [Care](#)
[>JCAHO](#) > [>Accredited Organizations](#) > [Publicizing Yo](#)

[Celebrate Your Accreditation](#)
[JCAHO Logo Guidelines](#)
[The Joint Commission:
Assessing the Quality of Care
Brochures](#)
[Facts About Joint Commission
Accreditation](#)
[Guidelines For Publicizing Joint
Commission Accreditation](#)
[Frequently Asked Questions](#)
[Promotional Materials](#)
[Sample News Releases](#)
[Accreditation Decisions](#)
[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospital Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

Accreditation Decisions

The Joint Commission has eight accreditation decision categories.

Accreditation with Full Standards Compliance (formerly Accreditation without Type I Recommendations) is awarded to a health care organization that demonstrates satisfactory compliance with applicable JCAHO standards in all performance areas.

Accreditation with Requirements for Improvement (formerly Accreditation with Type I Recommendations) is awarded to a health care organization that demonstrates satisfactory compliance with applicable JCAHO standards in most performance areas, but has deficiencies in one or more performance areas or in meeting accreditation policy requirements which require resolution within a specified time period.

Provisional Accreditation is awarded to a previously unaccredited health care organization that demonstrates satisfactory compliance with a subset of standards during a preliminary on-site evaluation. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately six months later.

Conditional Accreditation is awarded to a health care organization that:

- fails to demonstrate compliance with applicable JCAHO standards in multiple performance areas; or
- is persistently unable or unwilling to demonstrate satisfactory compliance with one or more JCAHO standard(s); or,
- fails to comply with one or more specified accreditation policy requirements, but is believed to be capable of achieving acceptable compliance within a stipulated time period.

Preliminary Denial of Accreditation results when it is determined that there is justification to deny accreditation to a

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LATEST FROM

JCAHO SHORT

- > [Shared Vision](#)
- > [Patient Safety](#)
- > [Quality Check](#)
- > [Datamart™](#)
- > [Speak Up](#)
- > [Standards On Submission Form](#)
- > [Publicizing Your Accreditation](#)
- > [Sign Up for Newsletter](#)
- > [Looking for a Codman Award](#)
- > [Eisenberg Award](#)
- > [Infomart](#)
- > [Education](#)
- > [Publications](#)

health care organization because the organization has failed to demonstrate satisfactory compliance with applicable JCAHO standards in multiple performance areas, or with accreditation policy requirements, or for other reasons. This accreditation decision is subject to subsequent review.

Accreditation Denied results when a health care organization has been denied accreditation. This accreditation decision becomes effective only when all available appeal procedures have been exhausted.

Accreditation with Commendation was awarded to a health care organization that demonstrated more than satisfactory compliance with applicable JCAHO standards in all performance areas on a complete accreditation survey prior to Jan. 1, 2000. Although this decision category has been discontinued effective Jan. 1, 2000, organizations awarded this decision as a result of surveys conducted during 1998 and 1999 will retain this designation until their next complete surveys, unless it is lost based on an intracycle evaluation.

Accreditation Watch, though not a separate accreditation decision, is a publicly disclosable attribute of an organization's existing accreditation status. An organization is placed on Accreditation Watch when a sentinel event has occurred and a thorough and credible root cause analysis of the sentinel event and an action plan have not been completed within a specified time frame. Following determination by JCAHO that the organization has conducted an acceptable root cause analysis and developed an acceptable action plan, the Accreditation Watch designation is removed from the organization's accreditation status.

Please see any of our accreditation manuals for additional information on accreditation decisions, policies, and procedures.



Hospitals

Accredited Organizations

[Hospital Home Page](#)
[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospital Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

Standards

Survey Process

[Survey Process](#)
[Business Associate Agreement](#)
[Guidelines for Written Progress Reports](#)
[Random Unannounced Surveys](#)
[Random Unannounced Surveys in 2003](#)

Preparing for Survey

Tailored Surveys

Multihospital System Option

Sample Forms and Tools

ORYX

FAQs about Hospital Accreditation

Sentinel Events

Organization Update Form

Survey Process

The length of your survey will depend on the scope and volume of services that your organization provides.

Opening conference

The survey begins with an opening conference on the morning of the first day. This conference will introduce the survey team to your key staff, and review and confirm the tentative survey agenda. Your chief executive officer will determine which staff members should attend the conference, which is generally limited to 30 minutes.

Document review

The survey team reviews documents that will orient them to the way your hospital functions. These documents focus on your hospital's performance and include:

- committee minutes
- reports of measurement and assessment activities
- reports to medical staff, hospital committees, and the governing body
- bylaws, planning documents, and other evidence of performance

The document review prepares surveyors for the interactive part of the survey. Surveyors do not score compliance until they have examined the hospital's performance during later survey activities.

Interviews with hospital leaders

Surveyors interview hospital leaders early in the survey. The surveyors want to see how the senior leaders work together to plan, design, implement, and improve patient care services. Other interviews examine the specific roles played by hospital administration, by medical staff and nursing leaders, and by departmental directors. These other interviews take place later in the survey so that the surveyors can use knowledge of the

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- > JCR Publishes Privileging, Credentialing, Peer Review: Compliance Focus
- > JCAHOnline

JCAHO SHORT

- > Shared Vision
- > Patient Safety
- > Quality Check
- > Datamart™
- > Speak Up
- > Standards On Submission Form
- > Publicizing Your Accreditation
- > Sign Up for Accreditation
- > Looking for a Codman Award
- > Eisenberg Award
- > Infomart
- > Education
- > Publications

hospital's performance to direct their questions.

Surveyors will interview the:

- CEO/person responsible for strategic planning and resource allocation
- medical staff leaders
- nursing leaders
- hospital department directors

Visits to patient care settings

The survey team may spend as much as half its time visiting places where patients receive care and services. These visits show the surveyors how the your hospital cares for its patients. Surveyors will also examine how you have implemented and improved your planning and design processes.

Visits to patient care settings include:

- inpatient units
- ambulatory/outpatient clinics
- emergency services
- rehabilitation facilities
- pathology and clinical laboratory services (if applicable)
- operating rooms
- anesthetizing locations
- imaging centers
- practitioner sites
- and other locations

During these visits the survey team may talk with managers, direct care providers, and patients. The team also reviews open medical records and looks at:

- environment of care
- infection control
- patient care
- staff communications
- patient rights issues

Function interviews

The surveyors conduct a series of interviews with multidisciplinary groups of hospital staff who have important responsibilities for specific functions. The surveyors ask questions that follow up on issues they have identified in the document review and visits to patient care settings. Function interviews include staff members responsible for:

- medication use/nutrition care
- anesthesia,
- patient care
- patient and family education

- operative, and other invasive procedures
- infection control
- human resources and medical staff credentials
- continuum of care
- information management
- performance improvement
- ethics

Other assessment activities

Certain survey activities involve staff with specific responsibilities related to the standards, for example:

- admitting services visit
- pharmacy services visit
- medical record interview
- building tour
- review of environment of care documents

Feedback sessions

Surveyors communicate their observations at daily briefings and during a medical staff conference luncheon (at your request).

Leadership exit conference

The leadership exit conference is held on the last day of your survey. The surveyors will give you a preliminary report, including a preliminary accreditation decision. The final decision is made at the Joint Commission's central office after we analyze the surveyors' written findings. However, during the conference you can discuss any findings you believe to be invalid, and present additional information that the surveyors may have overlooked.


[Hospital Home Page](#)
[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospital Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

Standards

Survey Process

[Survey Process](#)
[Business Associate Agreement](#)
[Guidelines for Written Progress Reports](#)
[Random Unannounced Surveys](#)
[Random Unannounced Surveys in 2003](#)

Preparing for Survey

Tailored Surveys

Multihospital System Option

Sample Forms and Tools

ORYX

FAQs about Hospital Accreditation

Sentinel Events

Organization Update Form

Guidelines for Written Progress Reports

The information provided within this guide will help you in preparing your written progress report (WPR) to address any requirements for improvement (formerly a type I recommendation). By following these guidelines, your organization's WPR can be efficiently and effectively reviewed by Joint Commission's central office staff. The topics that your WPR should address are found in the first few pages of your Official Accreditation Decision Report.

General Guidelines

- Include the cover sheet that was sent with your copy of the Official Accreditation Decision Report
- Clearly identify the grid element name, standard(s), and recommendation(s) for improvement to which you are responding
- Describe the actions, the results of the actions, and any follow-up activities for each recommendation for improvement you are addressing.
- Narratives describing compliance should be accompanied with supportive documentation. A recommendation for improvement will not be cleared by descriptive narrative only.
- Summarize your corrective actions using actual numbers and percentages, as appropriate.
- Track record of compliance: A one-month written progress report must evidence at least one continuous month of compliance; four- or six-month written progress reports must evidence at least four continuous months of compliance. The track record should begin any day after the last day of survey.

Include documentation of your organization's compliance for each recommendation for improvement you are addressing. Such documentation may include, but is not limited to, any of the following which appropriately addresses the recommendation:

- completed plans of care or treatment
- completed patient records
- signed and dated policies and procedures

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LATEST FROM

- > JCR Publishes Issues for End Departments
- > JCR Publishes Pain Manage
- > JCR Publishes Promise: Pro From Harm
- > JCR Publishes Privileging, C Peer Review: Compliance f
- > JCAHOnline

JCAHO SHORT

- > Shared Vision
- > Patient Safety
- > Quality Check
- > Datamart™
- > Speak Up
- > Standards On Submission F
- > Publicizing Y
- > Sign Up for N
- > Accreditation
- > Looking for a
- > Codman Aw
- > Eisenberg Av
- > Infomart
- > Education
- > Publications

- completed personnel records
- attendance records
- educational materials
- copy of license(s) or registration
- meeting minutes
- PI reports & worksheets
- competency assessments
- audit tools
- job descriptions
- photographs (for equipment management storage areas, pharmacy prep areas, EOC issues)

DO NOT SEND BLANK FORMS

All documents, such as logs, audit tools, evaluations, must demonstrate implementation. Blank forms are not sufficient to clear a recommendation for improvement.

IMPORTANT DO's and DON'TS**DO...**

- Describe the actions taken, the results and follow-up activity
- Format your response so that the documentation which reflects compliance is marked or highlighted
- Begin by explaining the format and content of your response
- Follow the guidelines below for submitting patient and/or employee records
- Make a copy of your report for your own records

DON'T...

- Send any originals (any documentation submitted with your report will NOT be returned)
- Mail a written progress report in separate parts
- Address supplemental recommendations
- Submit documentation reflecting activities prior to your survey
- Submit blank forms - evidence of implementation is needed to demonstrate compliance with the standards
- Request revision of the original survey documents

Resolution of track record issues

For track record issues, where a recommendation for improvement has been implemented prior to the end of survey, you are required to submit a description of your process for preventing similar events of noncompliance in the future. For example, if an individual lets his/her license lapse, and this was corrected in the month prior to survey, it is insufficient to merely show proof that the individual was licensed. You need to describe what systems you have put in place to detect and prevent staff from practicing without renewing their licenses. Evidence of implementation of any such process is required.

Record Submission

- Activities reflected in the record must have occurred after the survey
- Records should represent all sites addressed in the recommendation, when applicable
- Patient's/staff's identification should be removed or blacked out
- 10 records should be submitted when applicable or otherwise indicated in your Official Accreditation Decision Report

Please note that the documents and/or records you submit will become the property of the Joint Commission. We suggest you make copies of what you submit for your records. **We will not photocopy or return submitted materials.**

For any recommendation regarding Posting Public Notice

The written progress report submitted in one (1) month should include evidence of complying with the public information interview policy. Specifically, to be in compliance with this policy, the organization must inform its patients, employees, and the general public of the right to meet with a Joint Commission surveyor. This notice must be posted for one month beginning with the day this report is received. The organization will be required to submit evidence in a written progress report showing that all necessary persons were informed. An example of evidence for each group of persons might include: (1) a form letter to employees, 2) a form letter to patients, and 3) a newspaper clipping. This notice should be in the past tense and reflect the date that your organization had a survey conducted. Due to the fact that the organization did not comply with the public information interview policy, if a public information interview is requested, the organization will be required to conduct a post-survey public information interview at the organization's expense.



Hospitals

Accredited Organizations

[Hospital Home Page](#)
[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospital Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

Standards

Survey Process

[Survey Process](#)
[Business Associate Agreement](#)
[Guidelines for Written Progress Reports](#)
[Random Unannounced Surveys](#)
[Random Unannounced Surveys in 2003](#)

Preparing for Survey

Tailored Surveys

Multihospital System Option

Sample Forms and Tools

ORYX

FAQs about Hospital Accreditation

Sentinel Events

Organization Update Form

Random Unannounced Surveys

Since 1993, the Joint Commission has conducted one-day surveys at randomly selected accredited organizations. Unannounced surveys are an important way of showing that organizations remain in compliance with JCAHO standards throughout the accreditation cycle.

The following provisions apply to all accredited organizations, with the exception of laboratories and networks:

- Organizations receive no advance notice for random unannounced surveys.
- The surveys can be conducted from nine to 30 months after the triennial survey.
- Five percent of accredited organizations are selected on a proportionate basis across accreditation programs and accreditation decision categories.
- The unannounced surveys are conducted by a cadre of surveyors in each accreditation program who are specially trained in the use of the random unannounced survey protocols. One surveyor conducts each survey.
- The survey results may lead to new type I recommendations and may even cause a change in the organization's accreditation status.
- There is no cost charged to organizations selected for random unannounced surveys.

Variable Elements

During the survey, the surveyor will first assess organization-specific, or variable performance areas, based on the organization's last accreditation survey report, any complaint or performance data received since the last full survey, and other feedback and findings discovered onsite during the random, unannounced survey. This information allows the surveyor to verify sustained resolution of type I recommendations and evaluate performance areas relevant to the organization-specific information.

Fixed Elements

In addition, the surveyor will assess five fixed topics or performance areas that are the same for every type of organization. JCAHO chooses these areas because they contain

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LATEST FROM

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- > JCR Publishes Pain Management
- > JCR Publishes Promise: Protection From Harm
- > JCR Publishes Privileging, Credentialing, Peer Review, Compliance and JCAHOOnline

JCAHO SHORT

- > Shared Vision
- > Patient Safety
- > Quality Check
- > Datamart™
- > Speak Up
- > Standards and Submission Form
- > Publicizing Your Accreditation
- > Sign Up for News
- > Looking for a Codman Award
- > Eisenberg Award
- > Infomart
- > Education
- > Publications

standards related to a high percentage of type I recommendations, complaint and sentinel event statistics, or issues of public concern. They can be viewed for each program on the JCAHO Web site, see Random Unannounced Surveys in 2003.

JCAHO prioritizes elements based on the degree of actual or perceived risk to care and noncompliance with relevant standards in each area specific to the health care setting being reviewed.

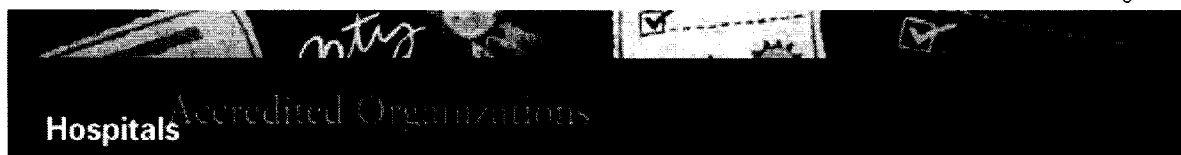
Presurvey information and findings for each organization differs, the extent of review required for the variable elements may not allow for time to assess each fixed element. As a result, in those organizations in which significant attention is devoted to variable performance areas, only the highest priority fixed elements will be addressed.

Benefits

Random unannounced surveys are a means for organizations to "fine-tune" their compliance with standards between triennial surveys, and to publicly show that they maintain their good performance on a day-to-day basis.


Joint Commission

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[Home](#) | [Who Am I](#) | [Search](#) | [Sitemap](#) | [Contact Us](#) | [Care](#)
[>JCAHO](#) > [>Accredited Organizations](#) > [>Hospitals](#) >

[Hospital Home Page](#)
[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospital Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

Standards

Survey Process

[Survey Process](#)
[Business Associate Agreement](#)
[Guidelines for Written Progress Reports](#)
[Random Unannounced Surveys](#)
[Random Unannounced Surveys in 2003](#)

Preparing for Survey

[Tailored Surveys](#)
[Multihospital System Option](#)
[Sample Forms and Tools](#)

ORYX

[FAQs about Hospital Accreditation](#)
[Sentinel Events](#)
[Organization Update Form](#)

Random Unannounced Surveys in 2003

The fixed topics for random unannounced surveys (RUSs) are shown below, in the order of highest priority. Under JCAHO's RUS policy, five percent of organizations accredited under the ambulatory care, behavioral health, home care (including pharmacies), hospital and long term care accreditation programs will receive a RUS. An organization can be selected between nine and 30 months after its full survey and will not receive any prior notice that a surveyor is coming. The surveyor will include a review of both "variable" and "fixed" performance areas.

Surveyors will first assess organization-specific (that is variable) performance areas based on the organization's last accreditation survey report, any complaint or performance data received since the last full survey, and other feedback and findings discovered onsite during the RUS. This information will allow the surveyor to verify sustained resolution of type I recommendations and evaluate performance areas relevant to the organization-specific information.

Beginning January 1, 2003, variable areas also will include an assessment of the organization's implementation of the specific recommendations for those JCAHO 2003 National Patient Safety Goals that are relevant to the organization's care and services.

In addition, surveyors will assess the "high risk" performance areas outlined below as time allows. Any of these fixed elements or performance areas may be reviewed in any RUS in each accreditation program.

The fixed RUS survey elements were chosen for various reasons, often because the grid element contains a standard(s) related to a high percentage of type I recommendations, complaint and sentinel event statistics, and issues of public concern.

These elements are prioritized based on the degree of actual or perceived risk to patient care and noncompliance, with relevant standards in each area specific to the health care setting being reviewed. Because the presurvey information and findings for each organization will differ, the extent of review required for the variable elements may not allow for time to assess each fixed

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Other Programs

LATEST FROM

- > JCR Publishes Issues for End Departments
- > JCR Publishes Pain Manage
- > JCR Publishes Promise: Pro From Harm
- > JCR Publishes Privileging, C Peer Review: Compliance f
- > JCAHOnline

JCAHO SHORT

- > Shared Vision
- > Patient Safety
- > Quality Check
- > Datamart™
- > Speak Up
- > Standards On Submission F
- > Publicizing Y
- > Sign Up for N
- > Accreditation
- > Looking for a
- > Codman Awa
- > Eisenberg Av
- > Infomart
- > Education
- > Publications

element and only the highest priority fixed elements may be addressed.

For questions about RUS topics, please contact Kevin Hickey at (630) 792-5872.

Top Elements for Unannounced Surveys in 2003

Ambulatory Care

Credentialing and Privileging of Licensed Independent Practitioners
Competence Assessment
Implementation
Improving Performance
Medication Use

Behavioral Health

Special Procedures
Initial Screening and Clinical Assessments
Medication Use
Assessment for Discharge-Planning Care Decisions and Reassessment
Clinical Data and Information

Home Care - Home Health

Planning and Provision of Care
Human Resources Management
Infection Control
Patient Assessment
Medication Administration

Home Care - Home Medical Equipment

Patient Equipment Management
Planning and Provision of Care
Human Resources Management
Infection Control
Patient Assessment

Home Care - Pharmacy Services

Human Resources Management
Patient Equipment Management
Planning and Provision of Care
Patient Assessment
Drug Preparation and Dispensing

Home Care - Hospice Services

Planning and Provision of Care
Human Resources Management
Medication Administration
Patient Assessment
Infection Control

Hospitals

Surveillance, Prevention, and Control of Infection

Initial Assessment
Role in Improving Performance
Medication Use
Human Resources Planning

Long Term Care

Assessment
Resident-specific Data and Information
Credentialing
Orientation, Training, Education, and Competency
Aggregation and Analysis

Long Term Care - Subacute Care

Orientation, Training, Education, and Competency
Credentialing
Assessment
Implementation
Aggregation and Analysis

Facts About Random Unannounced Surveys

[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospitals](#) | [Laboratory Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

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Accredited Organizations

[Hospital Home Page](#)
[Ambulatory Care](#) | [Assisted Living](#) | [Behavioral Health Care](#) | [Health Care Network](#) | [Home Care](#) | [Hospital Services](#) | [Long Term Care](#) | [Office-Based Surgery](#)

Standards

Survey Process

[Survey Process](#)
[Business Associate Agreement](#)
[Guidelines for Written Progress Reports](#)
[Random Unannounced Surveys](#)
[Random Unannounced Surveys in 2003](#)

Preparing for Survey

[Preparing for Survey](#)
[Guidelines for Document Review](#)
[Key Activities](#)
[Survey Agenda](#)
[Building Tour Checklist](#)
[Notifying the Public About a Joint Commission Survey](#)
[Environment of Care Interview](#)

Tailored Surveys

Multihospital System Option

Sample Forms and Tools

ORYX

FAQs about Hospital Accreditation

Sentinel Events

Preparing for a Hospital Survey

Preparing for a Joint Commission survey can be challenging. Your hospital must:

- Know the standards
- Examine your current processes
- Improve areas that are not currently in compliance

You must be in compliance with the standards for at least four months prior to your initial survey. For resurveys, we require a 12-month "track record" of standards implementation. However, we expect you to be in compliance with applicable standards during your entire period of accreditation, so surveyors will look for a full three years of implementation for several standards-related issues, including performance improvement activities.

For an initial survey, allow 9-12 months of preparation *before* your survey date. You'll have sufficient time to:

- Review the standards carefully
- Conduct an organizational self-assessment
- Take measures to improve where needed
- Develop new policies or processes
- Conduct staff training

The following checklist can help you prepare for an initial or triennial survey.

- ☐ Read all the information in the *Comprehensive Accreditation Manual for Hospitals* (CAMHC). This manual includes all the hospital standards as well as a section covering official Joint Commission accreditation policies and procedures. Read all the standards and determine their relevance to your hospital. Remember that you are responsible for items in the intent statements as well as in the standards; be sure to read the scoring guidelines. Surveyors will look for multidisciplinary or organizationwide approaches to the standards, so don't limit your compliance to specific departments or disciplines. The examples of implementation and the scoring guidelines can help you

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- > JCR Publishes Promise: Protection From Harm
- > JCR Publishes Privileging, C Peer Review: Compliance f
- > JCAHOnline

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- > Shared Vision
- > Patient Safety
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- > Speak Up
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understand the meaning of the standards and intent statements.

- ☐ Attend seminars to help you understand the standards. Besides the many seminars that we sponsor throughout the year, state hospital associations and other professional associations often give presentations on Joint Commission standards. Read some of the many publications and other resources on hospital standards and related topics. For answers to questions about a specific standard, call the Department of Standards at 630-792-5900.
- ☐ Network with colleagues from hospitals that have recently gone through the accreditation process. Attend professional association meetings or call your counterparts in other organizations. Online bulletin boards sponsored by professional associations can be particularly helpful.
- ☐ Ensure that staff understand how to comply with the standards. Develop programs to educate staff about new systems. The surveyors will interview staff members to see how well they understand your processes.
- ☐ Use the scoring guidelines in the CAMH to conduct a mock survey. Document any areas of partial compliance and noncompliance that you identify. Mock surveys are most helpful when conducted regularly throughout the accreditation cycle. Regular mock surveys help you judge your hospital's efforts at continuously improving performance and help you fix problems before surveyors arrive. Some organizations hire consultants to conduct mock surveys if they don't have the time or expertise to do it themselves.
- ☐ Review the results of your mock survey with your staff. Develop a plan to correct the problems you found and set priorities for improvement. Establish a realistic schedule for improvements. We offer several tools to assist you:
 - *The Complete Guide to the Hospital Survey Process*
 - *The Medical Staff Handbook: A Guide to Joint Commission Standards*
 - *Doing the Right Things Right: Case Studies in Strategies for Maintaining Survey Readiness*
 - *Hospital Survey Self-Assessment Checklist*

- *Score 100 for Hospitals*

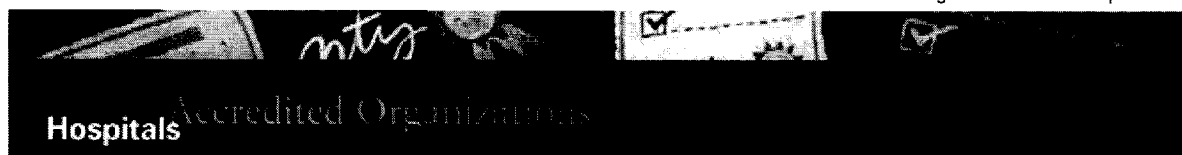
- Immediately before your survey, meet with your staff to review expectations and relieve anxiety. Reviewing what will happen during the survey will help boost staff confidence and help your people relax.

The best way to prepare for a survey is to incorporate the standards requirements into your daily activities. By continuously improving your hospital's processes, you can improve existing methods and correct problems before they become serious.

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Standards

Survey Process

[Survey Process](#)
[Business Associate Agreement](#)
[Guidelines for Written Progress Reports](#)
[Random Unannounced Surveys](#)
[Random Unannounced Surveys in 2003](#)

Preparing for Survey

Tailored Surveys

[Tailored-ISP](#)

Multihospital System Option

Sample Forms and Tools

ORYX

FAQs about Hospital Accreditation

Sentinel Events

Organization Update Form

Tailored Surveys Integrated Survey Process

The Joint Commission creates a tailored survey if your organization provides services covered by standards in more than one of our accreditation programs:

A tailored survey covers all the services your organization offers. If we'll survey your organization under more than one accreditation manual, you must comply with all applicable standards in each manual. Surveyors representing each accreditation program will be part of your survey team.

Although you will receive a separate preliminary report from each applicable accreditation program, your organization will receive only *one* accreditation decision for all the services you provide.

The Joint Commission will use an interim method for weighting survey results for organization components in the accreditation decisions of large, complex organizations surveyed after January 1, 2000. The interim method is intended to provide a large complex organization with an overall accreditation decision that reflects the performance of each of its components based on the size of the component. This change will diminish the impact that the poor performance of a single small component may have on the organization's overall decision. For any tailored survey, the Joint Commission will identify one program as "primary" (as is currently done), then determine the accreditation decision for the organization based on the following rules:

- If there are *any type I recommendations* in the primary or secondary (i.e., component) program of a complex organization, the highest accreditation decision possible for the organization is *Accredited with Type I Recommendations (becomes Accreditation with Requirements for Improvement on Jan. 1, 2002)*.
- If the primary program meets rules for either Conditional Accreditation or Preliminary Denial of Accreditation, the decision for the organization will be the same.
- If *one* of the secondary programs meets rules for Preliminary Denial of Accreditation, the decision for the

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organization will be *Conditional Accreditation*.

- If *one* of the secondary programs meets rules for Conditional Accreditation, the decision for the organization will be *Accredited with Type I Recommendations (becomes Accreditation with Requirements for Improvement on Jan. 1, 2002)*.
- If *two or more* of the secondary programs meet rules for Preliminary Denial of Accreditation, the decision for the organization will be Preliminary Denial of Accreditation.
- If *two or more* of the secondary programs meet rules for Conditional Accreditation, the decision for the organization will be *Conditional Accreditation*.

Integrated survey process

The integrated survey process replaces tailored surveys for the following organizations:

- Small hospitals (average daily census of less than 40) with long term care, home care, and/or behavioral health care services
- Small psychiatric hospitals (average daily census of less than 40) with long term care, home care, and/or behavioral health care services. Only non-government psychiatric hospitals with an average daily census greater than 40 may be eligible under the integrated survey process.
- Integrated delivery systems seeking network accreditation

The ISP reduces duplication by offering a single survey with one team of surveyors. The ISP evaluates performance only once for each function that the organization's services have in common. For example, under the ISP, one leadership interview replaces separate interviews for a hospital, behavioral health care program, long term care facility and home care service.

The ISP more accurately gauges the integration of services across the entire organization and identifies opportunities for the organization to improve efficiency.

Under the ISP for hospitals, upon completion of the survey each service component will receive preliminary survey reports and grids. The final report is integrated, providing a single accreditation decision and one report of recommendations for improvement.

The network ISP results in separate accreditation decisions for the network and for each individual care delivery site that is fully evaluated during the survey

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Standards

Survey Process

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[Guidelines for Written Progress Reports](#)
[Random Unannounced Surveys](#)
[Random Unannounced Surveys in 2003](#)

Preparing for Survey

Tailored Surveys

Multihospital System Option

Sample Forms and Tools

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FAQs about Hospital Accreditation

Sentinel Events

Organization Update Form

Checklist for Planning the Building Tour

To foster efficient use of time during the building tour, please note the following areas to be included. Sequencing of stops on the tour should reflect the locations of the areas to be visited in accordance with the listed priority.

The environment of care (Life Safety Code, security, emergency preparedness, general safety, hazardous materials, medical equipment management, utility management) and infection control issues are evaluated during the building tour with planned visits to the following areas:

1. Life Safety
2. Type of construction
3. Two exits
4. Fire separation (building to building or horizontal exits)
5. Smoke separations (at least two)
6. Fire alarm system
7. Any other observed conditions

Patient care settings visited for "above the ceiling" issues only:

Inpatient unit: _____ Inpatient unit: _____ Inpatient unit: _____

Inpatient unit: _____ Inpatient unit: _____ Inpatient unit: _____

8. Emergency generator (start-up procedure and results of tests)
9. Admitting services (when not separately scheduled)
10. Pharmacy (when not separately scheduled)
11. Loading/receiving dock and trash collection room/areas
12. Boiler room
13. Laundry, if applicable
14. Central storage/warehouse
15. Food service area
16. Clean and soiled linen room
17. Oxygen storage rooms
18. Chute terminal rooms
19. HVAC equipment rooms
20. Resource center

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FEATURE ARTICLE

PART 2:

NEW CLARIFICATIONS TO JOINT COMMISSION ENVIRONMENT OF CARE STANDARDS

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The following are additional clarifications to "Management of the Environment of Care" standards. The need for these clarifications were also identified by the combined efforts of the American Society of Healthcare Engineers (ASHE) and Joint Commission Environment of Care Task Force.

1. EC.1.1 (Life Safety Code compliance)

Problem a: *Surveyor misidentification of cross corridor fire doors, smoke doors, and doors used solely for traffic control. Many hospitals have been cited for non-labeled or improperly labeled fire-rated doors when the doors are not required to be labeled or fire rated.*

Clarification: The Plant Technology Management unit of the Joint Commission continually monitors LSC® recommendations made by surveyors and provides ongoing education to surveyors by a variety of methods including: annual education classes, telephone conferences, individual surveyor education consults, and mailings of the type of document you are currently reading. In addition, the new Statement of Conditions™ (SOC) document requiring organizations to provide a rough sketch floor plan of each story has eliminated many of these misinterpretations.

Because these graphic representations provided to the surveyor identify the major structural features of life safety that exist within an organization's building (i.e. exterior exit doors, exit stairs/ramps, smoke proof enclosures, horizontal exits, exit passageways, fire barriers, fire compartments, and smoke barriers), surveyors are not forced to make these determinations during the building tour.

Problem b: *Clarify the 18-inch clearance requirements between the bottom of automatic sprinkler heads and items of storage.*

Clarification: Per NFPA 13 (section 4-4.1.6), shelving, including storage thereon, shall not extend

above the level of a plane located 18 inches below ceiling sprinkler deflectors. (Exception: Where shelving is installed on a wall and is not located directly below ceiling sprinkler deflectors, the shelves, including storage thereon, may extend above a plane located below ceiling sprinkler deflectors.)

Problem c: *Clarify the types of penetrations/cracks that are not acceptable in fire walls and smoke barrier partitions above the architectural ceiling.*

Clarification: Where full-height, twenty-minute fire-rated corridor walls are required in a non-sprinklered building, a gap of an average dimension of no greater than one-eighth inch (1/8"), may surround a penetrating item above the ceiling. Where one and two hour fire rated walls or smoke barrier walls are required, the space between the penetrating item and the wall shall be filled with a material capable of maintaining the fire resistance rating of the wall.

2. EC.1.1 (Applicability of the Life Safety Code® and the Statement of Conditions)

Problem: *Clarify the Joint Commission's requirements for applicability of the Life Safety Code® and the statement of conditions.*

Clarification: The intent of standard EC.1.1 requires that a current, organizationwide Statement of Conditions™ compliance document (SOC) be prepared for every building housing and treating an organizations' patients regardless of ownership. These buildings shall be designed and maintained in accordance with the *Life Safety Code®* (LSC®), NFPA 101-1991.

The only exception to this standard are freestanding outpatient buildings classified as a business occupancy by the *Life Safety Code®* (LSC®). A business occupancy is the most common outpatient classification. However, if four or more outpatients receive treatment at the same time, rendering them

incapable of self-preservation in an emergency or requires general anesthesia, the LSC® classifies the outpatient setting as an ambulatory health care occupancy; all ambulatory health care occupancies must be in compliance with EC.1.1.

In either case, all inpatient or outpatient settings must have an effective *life safety management* program for protecting patients, visitors, and staff from fire, smoke, or other products of combustion. The content of this management program is described by standard EC.1.7 and must be implemented in accordance with standards EC.2.6, EC.2.10, and EC.2.12. Crucial to any life safety management program is the ability to quickly detect a fire, to notify occupants, to provide free and unobstructed egress to exits, and to maintain all existing building features of fire protection (i.e. exit signs, emergency lighting, portable fire extinguishers, etc.). In addition, all staff should be knowledgeable in the procedures to minimize the danger of fire and the procedures to be followed if a fire does occur.

3. EC.1.1 (Plan For Improvement)

Problem: *Clarify the requirements for a Plan For Improvement (PFI) to be acceptable (i.e. funding approval and time-frame requirements).*

Clarification:

- a. *Funding Approval Requirements*—Many times multi-year construction projects typically are not funded in total, but require ongoing approvals of capital budgets by a governing body. Therefore, a "commitment letter" signed by the organization's leaders (i.e. the Governing Body President and Chief Executive Officer) that includes time frames for all the different phases of the improvement project are acceptable in lieu of having all of the funds approved and available at the time of survey.
- b. *"Time-Frame Requirements"*—PFIs must be scheduled and completed within a time frame based upon each individual organization's overall planning, prioritization of performance improvement, and resource allocation processes. Therefore, the Joint Commission does not have an expectation that PFIs be completed within a specified time frame based upon a specific dollar amount (i.e. a five million dollar project within one year). It is each organization's responsibility to determine reasonable PFI's time frames based upon the risks associated each LSC® deficiency and

the availability of funds. If a LSC® deficiency will not be immediately corrected, appropriate Interim Life Safety Measures (ILSM) should be implemented to compensate for the risk presented by the deficiency. In addition, if a deficiency will be not corrected in the near future, the SOC's *Plan For Improvement (Long Form)* should be completed identifying those time frames for each major phase of improvement activities (design, bidding, phases of construction, etc.).

- c. While the Joint Commission surveyor makes the initial assessment of the PFI during survey, Joint Commission's central office has the final authority on the reasonableness of the PFI and can approve or reject a PFI based upon its findings.

4. EC.1.3 through EC.1.9 (Management Plans)

Problem: *Clarify the requirements for a Management Plan (i.e. format and length).*

Clarification: Standards EC.1.3 through EC.1.9 require that management plans be developed to give an overview on how the organization will provide a safe, functional, and effective environment of care. The design of these plans should be based upon the "uniqueness" of the organization (i.e. the services offered, their size, their geographic location, the condition and configuration of their physical environment, the technology present, etc.). These plans represent statements of an organization's level of concern for the safety and health of its patients, visitors, and members of its staff. They also provide the basis for an objective evaluation of the program's effectiveness and become a useful for orienting and educating staff.

But more importantly, these management plans relate to the organization's "owner or operator manual" for the environment of care management program(s). They become a road map as to how activities related to the environment of care will be orchestrated and conducted throughout the organization. Without them, the management of the environment of care would become a haphazard affair. The intent statements of this group of standards stress that certain **processes** need to be developed and documented which describe an overview of:

- a. the day-to-day, ongoing activities to *pro-actively* minimize physical risk in the environment of care (*routine work to support reliability* such as preventive maintenance of

- medical equipment and utility systems, inspection activities, risk assessment activities, material acquisition activities, etc.);
- b. the emergency behavior activities expected of staff when normal work processes are disrupted (*failure correction work* in response to events when components of the environment are stressed such as a utility system interruption, medical equipment failures, hazardous materials spills/exposures, security incidents, weather-related occurrences, emergencies in the surrounding community, etc.);
 - c. the orientation and continuing education activities of all personnel for becoming and remaining competent in their assigned roles and responsibilities while interacting with the environment of care (including in-house staff, leadership, contract employees, volunteers, students, etc.);
 - d. the activities for reporting and investigating problems, failures, and user errors that occur within the environment of care (including the manner in which information will be exchanged with the leaders of the organization); and
 - e. the activities for establishing and using performance measures in evaluating the effectiveness and improving the management of the environment of care program(s), including how the program will be evaluated annually in terms of its objectives, scope, performance, and effectiveness.

The EC standards do not prescribe a specific format for management plans. The processes required by the plans may be communicated through traditional written policies and procedures, but more efficient formats including matrixes, diagrams, charts, drawings, etc. should be considered (a picture can be worth ten thousand words). The main requirements are that whatever format is used, that it be easily understood and that the plans address all applicable staff, equipment and sites of care. Finally, there is no number of pages that the management plans must be; quality rather than quantity is the rule here.

5. EC.1.3 through EC.1.9 (Performance Standards)

Problem: Clarify the requirements for performance standards in the environment of care standards.

Clarification: The 1997 CAMH requires that at least one performance standard must be established for

each of the seven functions in environment of care standards (i.e. safety, security, hazardous material, etc.). Examples in the EC chapter list areas that lend themselves to management activities through the use of performance standards. These include staff knowledge and skill, monitoring and inspection activities, reporting and testing/preventive maintenance activities. The establishment of measurable EC performance standards in these and other areas developed by accredited organizations, allows performance to be easily assessed against expected outcomes and thereby facilitate the identification of areas for improvement in the environment of care.

For example, Community Hospital decided that the source of the data for assisting in making this assessment was its hazardous surveillance (safety inspection) records. The hospital's safety committee decided that it would analyze this data to track the following:

- a. number of hazards found;
- b. number of hazards that cause accidents;
- c. number of hazards corrected within (n) weeks; and
- d. number of hazards recurring at next surveillance period.

After determining the items to be measured, the hospital decided the level of performance expected. This was a difficult exercise since no level of injury or hazard is "acceptable." However, because there are real limits to the resources of any program, the hospital made a rational decision about the amount of each type of risk it is willing to accept before undertaking intensive evaluation of a situation. The following were the performance standards that the hospital established for their safety program:

- a. any recurrent hazards;
- b. any hazard/incident resulting in injury; and
- c. 10% of staff lacking knowledge about a specified subject.

6. EC.1.6 (Facility Evacuation)

Problem: Clarify the requirements for emergency preparedness drills relating to the use of actual patients and acceptable locations of alternative care sites.

Clarification: Actual patient movement, as part of mass-casualty emergency drill, has never been a Joint Commission requirement; actual patient movement can be dangerous and could lead to other problems. However, simulated patients need to be utilized since the point of the exercise is to learn

how an organization may improve performance when they are under stress and their resources are taxed.

The standards require the selection of an "alternative-care site" in the event the organization's environment can no longer support adequate patient care. While the standards do not prescribe that the alternative care site be a specific distance away, the selection process should evaluate the possibility of the alternative site being impacted by the same disaster (i.e. a hospital on the coastal waters of Florida should consider selecting an alternative care site more inland if evacuation needs to occur because of a hurricane).

7. EC.1.7 (Portable Fire Extinguishers)

Problem: Clarify the Joint Commission's inspection requirements for portable fire extinguishers.

Clarification: Joint Commission requires that all portable fire extinguishers be visually inspected at least quarterly to determine whether the extinguisher is the proper type for its location, is fully charged, is in good physical condition, and is in place.

However, the organization's management plans for life safety should include the most stringent requirement whenever there is a conflict between federal or local or state standards, codes and regulations. Therefore, if an organization's management plan requires monthly inspection of fire extinguishers because of a OSHA requirement, a surveyor will look for evidence of monthly inspections during the building tour.

8. EC.1.8 (Medical Equipment Failure Procedures)

Problem: Clarify the requirements for the clinical intervention procedures in the event of equipment failures.

Clarification: Medical equipment or utility system components which meet the organization's criteria for "critical to patient safety" must have emergency procedures in the event of malfunction or failure. The concept of "critical to patient safety" is generally intended to include life support, life sustaining or other such high-risk equipment, component, or system in which a malfunction or failure would most likely result in an adverse patient outcome.

The standards neither prescribe the scope of equipment or components considered critical to patient safety nor the level of redundancy that may be necessary should a malfunction or failure occur. Each organization needs to make that assessment

and determination.

9. EC.1.9 (Utility System Tests)

Problem: Clarify the requirements for inspecting, testing, and maintenance of critical operating components of utility systems.

Clarification: The intent of the standard requires organizations to develop criteria for identifying, evaluating, and taking inventory of critical operating components of systems to be included in the utilities management program. These criteria address the impact of utility systems on life support systems, infection control systems, environmental support systems, equipment support systems and communication systems. For these components/systems, a mechanism should be established to ensure that appropriate inspection, testing and maintenance is accomplished in accordance with manufacturers' recommendations, codes, standards, federal, state and local laws and regulations as well as the maintenance history of the system/component.

10. EC.2.1 (Staff Education)

Problem: Clarify the expectations of staff knowledge for the Environment of Care.

Clarification: Accredited organizations are expected to develop an orientation and education program based upon requirements of the standards of HR 4. The content of these programs needs to include those items listed in the intent of standards EC 1.3- EC 1.9 and EC 2.1. These programs are expected to be tailored to meet organizational needs and methods utilized to orient and educate staff including employees, volunteers, and students.

Surveyors utilize different techniques to evaluate staff members' knowledge, skills, and their roles and responsibilities in the seven EC programs. The techniques utilized and the priority of their evaluation vary based on the surveyors' observations during the various survey activities. This may give an impression of different expectations from individual surveyors that in reality is not true.

11. EC.2.6 (Interim Life Safety Measures)

Problem: Clarify the requirements for implementing all eleven Interim Life Safety Measures whenever life safety compensation is necessary.

Clarification: The Interim Life Safety Measures are applicable when the life safety provided to patients is diminished because of significant Life Safety Code® deficiencies or hazards of construction operations. Each organization must have a policy for

Interim Life Safety Measures that includes written criteria to evaluate deficiencies and construction hazards for determining when and to what extent one or more measures is applicable. The criteria used to determine which of the measures would be the most appropriate for a particular construction project, phase of construction, or deficiency may include (but are not limited to) construction activities or deficiencies present that:

- alter or compromise the integrity of exit access, exit, or exit discharge features;
- significantly compromise (as defined by each organization) the integrity of the building's "defend-in-place" compartmentation features (i.e. fire barriers, smoke barriers, floor slabs, corridor walls, etc.);
- impair the building's fire alarm, fire detection, or fire suppression systems;
- involve temporary sources of ignition (i.e. cutting/welding/plumbers torch operations); or
- involve the presence of large quantities (as defined by each organization) of combustibles and debris.

Each construction project or deficiency contains numerous variables that preclude absolute use of Interim Life Safety Measures in a rigid manner. By establishing written criteria, organizations are provided both discretion and flexibility in defining the circumstances under which Interim Life Safety Measures will be implemented to ensure the mitigation is closely matched to the risk.

12. EC.2.9 (Emergency Preparedness Drills)

Problem: Clarify the frequency and time requirements between emergency preparedness drills.

Clarification: The intent of the standard requires that the emergency preparedness plan is executed twice a year, either in response to an emergency or during a planned drill. Organizations that offer emergency services or are designated as disaster-receiving stations must perform at least one exercise yearly that include an influx of volunteer or simulated patients. Exercises must be conducted at least four months apart and no more than eight months apart.

The area of confusion appears to arise in the definition of twice a year. The Joint Commission expects organizations to conduct two exercises of the emergency preparedness plan within the 12-month period preceding the survey and that these drills be at least four months apart. The following

example of implementation is depicted in the 1996 CAMH at standard EC 2.9: *An organization conducts a emergency drill in December and in April and August of the following year. The April drill is acceptable because it is separated by four months from the previous and succeeding drills.*

13. EC.2.10 (Fire Drills)

Problem: Clarify the requirements for fire drills.

Clarification: The intent of standard EC.2.10 requires that all personnel on all shifts participate in one fire drill per quarter in all occupied buildings to monitor the efficacy of the organization's fire plan. Such a plan should include information on the use of alarm systems and signals, location and use of fire fighting equipment and methods of fire containment. Specific evacuation routes and procedures should be developed according to a facility's occupancy type. The drill should not be held at shift change because it may present an unrealistic picture as to the number of staff likely to be available at the time a fire occurs.

The Joint Commission does not hold an absolute expectation that an organization must assure that every person within the organization participate in one drill each quarter. However, organizations should understand their own staffing patterns to the extent that they schedule drills when it will involve the largest group of employees who need to participate. If people are working other than traditional eight-hour shifts, their staffing patterns must be evaluated to ensure they are included in the required drills.

For example, Community Hospital performs one organizationwide fire drill per each traditional eight-hour shift each quarter. In addition, the hospital recognized, through employee interview sampling during hazard surveillance surveys, that a significant number of personnel who work 12-hour shifts in ICU and part-time employees that work weekends in the ER department do not always participate in one fire drill per quarter. The organization's safety committee decided to schedule an additional fire drill per quarter in these departments. These departmental fire drills did not involve the rest of the organization or actual activation of the fire alarm, but did provide an opportunity to evaluate staff performance in implementing all other components of the their fire plan.

14. EC.2.12 (Fire Alarm Testing)

Problem: Clarify the requirements of fire alarm sys-

tem testing.

Clarification: Organizations are expected to demonstrate and document that all fire alarm and detection system circuits are tested on a quarterly basis (unless it is an intelligent system) and all components receive annual maintenance as is defined in the intent of standard EC.2.14. Organizations are expected to develop appropriate testing procedures to insure that fire alarm system testing is done properly. Surveyors should look for documentation that the required testing has been accomplished in accordance with procedures developed by the organization.

15. EC.2.14 (Emergency Generator Testing)

Problem: Clarify the requirements for emergency generator testing relating to the "30:50 rule."

Clarification: Demonstration of the emergency power system's reliability by conducting monthly testing of each generator for at least 30 minutes under a dynamic load that is equal to or greater than the higher of the following load values:

- 30% of the nameplate rating of the generator, after applying any applicable rating factors for site conditions; or
- 50% of either the calculated or greatest known load on the essential electrical distribution Emergency Power Supply System (EPSS).

Organizations may choose to test less than 30% of the emergency generator's nameplate or 50% of the total emergency power supply system (EPSS) load. These organizations shall (in addition to performing a monthly test for 30 minutes under operating temperature) comply with this standard by revising their existing documented management plan to conform to current NFPA 99 and NFPA 110 testing and maintenance activities. These activities shall include inspection procedures for assessing the evidence of wet stacking*.

Furthermore, performing an additional resistive load bank or load run test is only required when diesel powered generators show evidence of wet stacking, as determined from these inspection procedures. The following are the requirements for this test:

- Duration—until the exhaust is clear of black smoke, but not less than two hours; and

*As per NFPA 110, section 6-4.2 (1996 edition), wet stacking is a field term indicating the presence of unburned fuel and/or carbon in the exhaust system. Its presence is readily indicated by the presence of black smoke during engine-run operation.

- Load—greater than or equal to 80% of nameplate.

16. EC.3.2 (Safety Committee)

Problem: Clarify the requirements for clinical service representation on the safety committee.

Clarification: The 1997 *Comprehensive Accreditation Manual for Hospitals* states, "The organization has a multidisciplinary group (often known as the safety committee) composed of representation from administration, clinical services, and support services to carry out analysis of and seek resolution of safety management issues. Clinical service representatives may include physicians, nurses, pharmacists, laboratorians, or others appropriate to the hospital's mix of patient care providers." This is meant to imply that while it makes good sense to include physician on the safety committee to review certain issues, the standards do not require it.

17. EC.5 (Smoking)

Problem: Clarify where smoking is permitted in a healthcare environment.

Clarification: Patients, visitors, and staff are prohibited from smoking in any of the organization's buildings.

However, there may be medical reasons to permit some patients to smoke while in the organization (for example, if sudden withdrawal may interfere with the patient's treatment). The smoking policy provides for such exceptions when authorized by a licensed independent practitioner based upon criteria approved by the medical staff.

In addition, settings that provide longer-term care may have a policy that allows patients to smoke without a licensed independent practitioner's written authorization. In these instances, smoking may occur in designated locations that are environmentally separate from all patient care areas.

When the hospital allows these patient populations to smoke,

- smoking may occur within the organization's building(s);
- the hospital acts to minimize the smoke to the greatest extent possible;
- the hospital discourages all such smoking; and
- the hospital provides education and options for smoking cessation activities.

These standards do not require that a designated patient smoking area be a specific distance from patient care areas. A separate, well-ventilated room

(such as a designated smoking lounge for authorized patient smoking) is an acceptable smoking area. Hospitals shall always prohibit smoking (i.e. no medical exceptions allowed) for all outpatients and for all child or adolescent patients. Visitors and staff within all building(s) of the hospital may never smoke. The standards permit unrestricted smoking

outside the building if it is located in an area posing a limited fire threat to the building, and is out of the path of egress into the building (this is avoid exposure of secondhand smoke to other patients, visitors, and staff). The standards do not prescribe that these outside smoking areas be a minimum distance from the organization's building.

KEY TO CODE WRITING ORGANIZATIONS & SOURCES

- NFPA:** National Fire Protection Association
1 Batterymarch Park
Quincy, MA 02269

(800) 344-3555
- JCAHO:** Joint Commission on Accreditation of Health Care Organizations
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

(708) 916-5800
- CGA** Compressed Gas Association, Inc.
1725 Jefferson Davis Highway, Suite 1004
Arlington, VA 22202-4102

(703) 412-0900 Ext #799
- ASW** American Welding Society, Inc.
NW Lejune Road
Miami, Florida 33126

(800) 443-9353 ext 270
- ASTM** American Society for Testing and Materials
100 Barr Harbor Drive
West Conshohocken, PA 19428-2959

(610) 832-9585
- USP/NF:** United States Pharmacopia
12601 Twinbrook Parkway
Rockville, MD 20852

(301) 881-0666
- AIA:** American Institute of Architects
Committee on Architecture for Health
1735 New York Ave., N.W.
Washington, D.C. 20006

(202) 626-7300

**ITEMS LISTED ON THE DOCUMENTATION REVIEW SHEET PROVIDED
TO SURVEYOR UPON ARRIVAL:**

1. Utilities Management Plan
2. Medical Gas System (last testing, inventory and PM)
3. Infrared testing and last inspection of electrical distribution systems
4. Testing log of Battery powered lights for Inverter Power System and UPS (Main hospital has no battery power lights)
5. Generator log for 12 months
6. Standard Operating Procedures
7. Utilities failures report to Safety Committee
8. Water and Airborne Policy changes
9. Testing of temperature and humidity in Laboratory and OR
10. Air exchange documentation testing in OR and Isolation Rooms

Taber, Donald S. (CIV)

From: Joint Commission Resources-I5 [Joint_Commission_Resources-I5.UM.A.2557.291@jcrinc.post.intellimedia.com]
Sent: Wednesday, April 02, 2003 6:44 PM
To: Taber, Donald S. (CIV)
Subject: The latest news on JCAHO decisions

Joint Commission Resources Inc. (JCR) is pleased to send you this update containing up-to-the-minute news, practical tips, and information about new and revised JCAHO requirements. More information on all of these changes will be included in an upcoming issue of Joint Commission Perspectives.

Self assessment changed to Periodic Performance Review

In order to more accurately reflect everything encompassed in the self-evaluation element of Shared Visions-New Pathways, the name has been changed from self assessment to Periodic Performance Review. Because the organization not only conducts a self assessment, but also creates plans for corrections and identifies measures by which to judge their success at implementing those plans, referring only to a self assessment did not fairly represent the essence of the process.

All of the following items have been approved by Joint Commission committees and are currently pending approval by the JCAHO's Board of Commissioners.

Two new Accreditation Participation Requirements approved for 2004

-Use of a Periodic Performance Review in the accreditation process. JCAHO's Accreditation Committee approved a new Accreditation Participation Requirement (APR) for implementation in January 2004 for ambulatory care, behavioral health care, home care, hospital, and long term care. This APR requires that these organizations complete a Periodic Performance Review (formerly called a self assessment) and corrective action plan at the 18-month point in their accreditation cycle and submit it to the Joint Commission.

Failure to meet this APR within 30 days of the self-assessment due date can result in an organization being placed in Provisional Accreditation. Failure to do so within 60 days can result in Conditional Accreditation and can lead to accreditation being denied if the organization doesn't meet the requirement in one final opportunity.

-Prohibiting the use of JCAHO surveyors as consultants on accreditation-related issues. Another new APR was approved for January 2004 implementation in all accreditation programs. This APR requires that health care organization not knowingly use JCAHO surveyors to provide accreditation-related consulting services. Part of this requirement is the expectation that health care organizations will ask potential consultants if they are JCAHO surveyors.

Failure to comply with the APR will enact JCAHO's Information Accuracy and Truthfulness policy. Falsification, as the term is used in this policy, applies to both commissions and omissions in sharing information with JCAHO. The Joint Commission immediately takes action to deny accreditation or remove the accreditation award for an accredited organization whenever JCAHO is "reasonably persuaded that an organization has provided falsified information," the policy states.

As of January 2004, Joint Commission surveyors will be prohibited from

Taber, Donald S. (CIV)

From: Stan Clement [sclement@safemgt.com]
Sent: Tuesday, April 15, 2003 5:37 PM
To: Taber, Donald S. (CIV)
Subject: Important Change to JCAHO Survey Process

JCAHO has just announced (April 3, 2003) its decision to implement unannounced surveys for all hospitals beginning January 2006 [<http://www.jcaho.org/news+room/news+release+archives/unannounced+surveys.htm>]. The implications of this discussion will be far-reaching and for the first time in JCAHO's history, organizations will truly need to be in compliance and prepared for survey at all times.

Relative to the Environment of Care® (EC), the effects will be profound. Safety Management Services, Inc.'s (SMS, Inc.) experience with hospital EC programs is they are rarely in a condition to be surveyed until a month or so prior to the scheduled date. Our analysis of the situation is that hospital safety and facility leaders will have to adjust this routine dramatically to accommodate this new process.

While all the EC standards and intent statements are important and should be kept current at all times, the following are areas of particular vulnerabilities which should be kept under the closest scrutiny:

- Management Plans

Healthcare organizations are dynamic places and change occurs quickly. As major changes occur related to services, geography and technology, Management Plans should be updated to reflect these changes. Safety Management Services, Inc. recommends these plans be serviced at least annually to insure they are current.

- Annual Evaluation

In the past minor (and sometimes major) lapses in annual evaluations were either overlooked or not detected. Now it will be more critical to have these evaluations done for each of the three years between surveys and done in a timely fashion. Safety Management Services, Inc. strongly suggests that annual evaluations be done within 60 days of year end.

- Performance Measures

Many organizations list performance measures in their Management Plans but are only able to show evaluation of these measures within the last few months prior to survey. Now that organizations will not know when their survey is coming, it will be more important to maintain a relative strict schedule of evaluating and reporting on performance measures. SMS, Inc. recommends not less than semi-annual analysis and reporting.

- Statement of Conditions® (SOC)

SOC and PFI are probably the most vulnerable area. The history of many organizations is to not keep these documents current and to frequently blow deadlines. Blown SOC's, if identified, can have an extremely adverse effect, up to and including possible non-accreditation. These documents should be reviewed and updated no less than semi-annually and preferably quarterly.

- Interim Life Safety Measures (ILSM)

Keeping records current or ongoing construction activities will help avoid an unnecessary and unwanted deficiency during announced surveys.

The second tier of items requiring regular attention include documentation of fire drills, disaster drills, pre-construction risk assessments, preventive maintenance, hazard surveillance, fire protection equipment testing, and training records. While ongoing compliance with all JCAHO EC standards is important, the ones identified above will be some the more

critical ones during an unannounced survey.

SMS, Inc. has numerous services and products to assist organizations in staying in a state of continuous readiness for EC, particularly our Accreditation Maintenance Program™. The intention of this program is to provide a series of scheduled and comprehensive on-site consultations and support so a healthcare facility never falls too far from true JCAHO survey readiness. Visits from SMS, Inc. senior staff consultants are structured to provide the on-going audit of your EC programs, and to provide the materials, documentation and other services related to JCAHO standards compliance. The AMP is an "EC Tune-up" - a program designed to keep your facility running smoothly between surveys and to provide expert representation during the survey.

If you would like further information on our Accreditation Maintenance Program or any other SMS, Inc. services, please contact our marketing department at (847) 577-6550 x224 or via email at info@safemgt.com.

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Generic Scoring Guidelines							
Score	Quantitative	Qualitative			Track record		
		Descriptive	Extent	Frequency	Full surveys	Initial or focused	
1	91 - 100%	Full intent of standard met with very minor exceptions.	Substantial	Always	3-12 months	3-4 months	
2	76 - 90%	All major requirements met, but lesser ones are not.	Significant	Usually	9-11 months	3 months	
3	51 - 75%	Marginally meets all major requirements; OR fully meets some, but not others.	Partial	Sometimes	6-8 months	2 months	
4	26 - 50%	Minor expectations met, but basic intent not addressed.	Minimal	Rarely	1-5 months	1 month	
5	0 - 25%	Totally unresponsive to the intent of the standard.	Non-compl	Never	No implementation	No implementation	

Scoring Scales—Quantitative and Qualitative Measurement of Organization Performance

Most Restrictive

Score 1	100%
Score 2	--
Score 3	95% to 99%
Score 4	--
Score 5	Less than 95%

More Restrictive

Score 1	100%
Score 2	95% to 99%
Score 3	90% to 94%
Score 4	85% to 89%
Score 5	Less than 85%

Moderately Restrictive

Score 1	100%
Score 2	95% to 99%
Score 3	90% to 94%
Score 4	80% to 89%
Score 5	Less than 80%

Less Restrictive

Score 1	100%
Score 2	90% to 99%
Score 3	76% to 89%
Score 4	51% to 75%
Score 5	Less than 51%

Least Restrictive

Score 1	91% to 100%
Score 2	76% to 90%
Score 3	51% to 75%
Score 4	26% to 50%
Score 5	Less than 26%

Generic Qualitative Format

Score 1 Meets all performance expectations **and** structural requirements of the standard and its Intent

Score 2 Meets all performance expectations **and**, with a few minor exceptions, all structural requirements of the standard and its Intent

Score 3 Does **not** meet all the structural requirements **but** does, with a few minor exceptions, meet the performance expectations of the standard and its Intent

Score 4 Performance expectations are rarely met

Score 5 Organization does not meet performance expectations

NA Requirement is not applicable to this type of organization or patient population

When evidence of performance is either present or absent, the following scores can be used

Score 1	YES
Score 5	NO

1996 Generic Format (standard as question)

Score 1	Yes
Score 2	With a few minor exceptions
Score 3	Not consistently
Score 4	Rarely
Score 5	No